SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF NEW YORK

JEFFREY FARKAS, M.D., LLC, d/b/a INTERVENTIONAL NEURO ASSOCIATES,

Plaintiff,

-against-

GROUP HEALTH INCORPORATED and MULTIPLAN INC.,

Defendants.

Index No. 157629/2018

COMPLAINT

JURY TRIAL DEMANDED

Plaintiff Jeffrey Farkas, M.D., LLC, d/b/a Interventional Neuro Associates ("Plaintiff"), by and through its attorneys, Schwartz Sladkus Reich Greenberg Atlas LLP, by way of Complaint against Group Health Incorporated ("Defendant GHI"), and MultiPlan Inc. ("Defendant MultiPlan") (collectively, "Defendants"), alleges as follows:

PARTIES

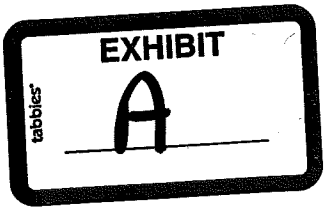
1. Plaintiff is a New Jersey limited liability company registered to do business in the State of New York with a principal place of business at 43 Westminster Avenue, Bergenfield, New Jersey, 07261.

2. Upon information and belief, Defendant GHI is a New York corporation with its principal place of business at 441 Ninth Avenue, New York, New York, 10001.

3. Upon information and belief, Defendant MultiPlan is a New York corporation with its principal place of business at 115 Fifth Avenue, New York, New York, 10003.

FACTUAL BACKGROUND

4. Plaintiff is a medical provider comprised of a team of neurologists who specialize in acute treatment following strokes, brain aneurysms, carotid disease, and vascular problems of the brain, spine, and neck.



5. Plaintiff's doctors perform major brain surgery in emergency, and often lifesaving, situations.

6. Upon information and belief, Defendant GHI is primarily engaged in the business of providing and/or administering health care plans or policies.

7. On May 23, 2017, Plaintiff's physicians performed emergency brain surgery on Defendant GHI's member, Noe S. ("Patient"), in the NYU Langone Medical Center in Brooklyn, New York, after Patient suffered a parietal lobar intracranial hemorrhage, also known as a stroke. (See, OP Report, attached hereto as **Exhibit A.**)

8. Subsequently, Plaintiff submitted a Health Care Financing Administration ("HCFA") medical bill to Defendant GHI demanding payment for the performed treatment in the total amount of $137,386.77. (See, HCFA, attached hereto as **Exhibit B.**)

9. As an out-of-network provider, Plaintiff does not have a network contract with Defendant GHI that would determine or limit payment for Plaintiff's treatment of Defendant GHI's members.

10. On or around August 23, 2017, Plaintiff received a single-case agreement (hereinafter referred to as the "Agreement") from Defendant MultiPlan to accept $107,000.00 from Defendant GHI, as payment in full for Plaintiff's medical services. (See, Agreement, attached hereto as **Exhibit C.**)

11. The Agreement specifically indicates that payment would be released "within 4 business days from date of receipt of faxed/digital signature." *Id.*

12. The Agreement further indicates that by accepting $107,000.00 as payment in full for Plaintiff's services, Plaintiff agrees "not to balance bill the Patient for the difference between the Amount of the Claim/Bill and the Agreed Amount." *Id.*

13. On August 23, 2017, Plaintiff accepted Defendant MultiPlan's proposed Agreement by signing and submitting it to Defendant MultiPlan, as per the instructions set forth in the Agreement.

14. As of November 13, 2017, Plaintiff had still not received any payment from either Defendant for Plaintiff's treatment of Patient.

15. Therefore, on November 13, 2017, Defendant submitted a "First Level Appeal" demanding payment in the amount of $107,000.00, as delineated in the Agreement that Plaintiff executed on August 23, 2017. (See, First Level Appeal, attached hereto as **Exhibit D.**)

16. On November 17, 2017, Defendant GHI issued payment in the amount of $5,312.35 for Plaintiff's treatment of Patient.

17. On December 4, 2017, Plaintiff submitted a "Second Level Appeal" emphasizing that the agreed upon reimbursement for the subject treatment was $107,000.00, and demanding the remaining balance. (See, Second Level Appeal, attached hereto as **Exhibit E.**)

18. For the next several months, Plaintiff corresponded with representatives of each Defendant, attempting to reconcile the outstanding balance.

19. On April 28, 2018, Defendant GHI recouped its prior payment of $5,312.35 by offsetting a subsequent and unrelated medical claim submitted by Plaintiff.

20. On June 26, 2018, Defendant GHI issued a subsequent payment for Plaintiff's treatment of Patient in the amount of $9,109.35. (See, **Exhibit F**, attached hereto.)

21. As Plaintiff has not received any additional payments, and the sole prior payment was recouped, the June 26, 2018 payment of $9,109.35 serves as the total payment issued by Defendants to Plaintiff for the treatment of Patient in this matter.

22. As a result of Defendants' breach of the Agreement, a balance of $97,890.65 remains due and owing.

First Cause of Action
(Breach of Contract—Against All Defendants)

23. Plaintiff repeats and realleges the allegations set forth in paragraphs 1 through 22 of the Complaint as though fully set forth herein.

24. The Agreement is a valid and binding contract between Plaintiff and Defendants.

25. Plaintiff performed all of its obligations under the Agreement.

26. Defendants breached the Agreement by failing to pay Plaintiff for the amount due and owing thereunder.

27. Plaintiff has repeatedly demanded that Defendants abide by the terms of the Agreement, and pay the balance owed in the amount of $97,890.65; however, Defendants have failed and refused to satisfy their obligations pursuant thereto.

28. Plaintiff has incurred, and continues to incur, costs and expenses, including attorneys' fees, in collecting the sums due under the Agreement.

29. As a result, Plaintiff has been damaged in the amount of $97,890.65 representing the balance due and owing pursuant to the Agreement.

WHEREFORE, Plaintiff demands judgment against Defendants as follows:

A. On the First Cause of Action, against all Defendants, for money damages in an amount to be determined at trial, but in no event less than $97,890.65, together with interest thereon; and

B. For such other and further relief as the Court may deem just and equitable, including the costs, expenses, and attorneys' fees incurred in prosecuting this action.

Dated: New York, New York
August 15, 2018

SCHWARTZ SLADKUS
REICH GREENBERG ATLAS LLP
Attorneys for Plaintiff

By: 

Michael Gottlieb
270 Madison Avenue
New York, New York 10016
(212) 743-7000

EXHIBIT A

NYU Langone Radiology
NYU Lutheran
150 55th Street, 3rd Floor
Brooklyn, NY 11220-2508
718-630-7400

Ambooj Tiwari

Pt Name: [redacted]
MRN: 12120401
Referring: Nadia Persaud
CC Recipient(s):
Pt Phone: 917-860-3810

Procedure(s)	Accession Number(s)	Date of Service
IR ANGIO CEREBRAL ARTERY BILATERAL	13316283	5/23/17

FINDINGS:

PROCEDURE: Diagnostic cerebral angiogram

DATE OF SERVICE: 5/23/2017

PRE-OPERATIVE DIAGNOSIS/INDICATION: Left high parietal lobar intracranial hemorrhage

POST OPERATIVE DIAGNOSIS: Left high parietal lobar intracranial hemorrhage

REFERRING PHYSICIAN: Dr. Arcot

PERFORMING PHYSICIAN/SURGEON: Dr. Ambooj Tiwari

ASSISTANT/S: Dr. Selas

CONSENT: Informed consent was obtained for the procedure after discussing the potential risks and benefits of the procedure. Potential risks such as vascular injury, vascular occlusion, further stroke, intracranial hemorrhage and even death were discussed. After I answered all their questions they gave their informed consent.

ANESTHESIA: Monitored Anesthesia Care

PREOP MEDICATIONS: None

NYU Langone MEDICAL CENTER

NYU Langone Radiology
NYU Lutheran
150 55th Street, 3rd Floor
Brooklyn, NY 11220-2508
718-630-7400

PREP: After the patient was placed under anesthesia, both groins were prepped and draped in the usual sterile fashion. A timeout procedure was documented, the patient's name date of birth and medical record number as well as the procedures to be performed was confirmed by the entire team, after everyone in the room agreed, the procedure continued.

INTRODUCTION:
5 French micropuncture kit was used to obtain access to the right common femoral artery. After predilatation with a 4 French dilator, a 5 French sheath was inserted into the right common femoral artery over the 0.35", 45 cm J-wire. The sheath was then connected to a continuous heparinized saline flush and a right common femoral angiogram obtained to ascertain sheath placement.
Via the sheath a 5French diagnostic catheter was introduced over a Terumo glide wire, into the abdominal aorta, the catheter was than double flushed and subsequently hooked up to a separate continuous heparinized flush system.

VESSEL SELECTION:
The diagnostic catheter then was used to select the following vessels with the help of the Glidewire:

The right common carotid artery were selected. Cervical views followed by intracranial views were obtained. 36223

The left common carotid artery were selected. Cervical views followed by intracranial views were obtained. 36223 76377
3-D rotational angiograms of the intracranial circulation were also obtained. Independent processing of the source images of the 3-D rotational angiograms was done on a separate dedicated workstation for reconstruction. These reconstructions were then personally reviewed and interpreted by me. Based off these reconstructions and interpretations, I also obtained focused high definition magnified images of the lesion.

The right subclavian artery was selected, cervical views were obtained. 36225, 75710
The right vertebral artery was selected, cervical and intracranial views were obtained 36226

DIAGNOSTIC IMAGING FINDINGS:

Right common carotid artery:
Right common carotid artery is of good caliber. Right cervical ICA has minimal evidence of atherosclerosis at its origin Right internal carotid artery is of good caliber. Right ophthalmic artery and anterior choroidal artery are visualized. Right posterior communicating artery is visualized. Right MCA and its branches are visualized. Right ACA and its branches are visualized. Capillary filling and venous drainage is normal.
There is no evidence of any intracranial/extracranial dural AV fistulas or AV malformations on these images.

Left common carotid artery:
Left common carotid artery has a good caliber. Left cervical ICA has minimal evidence of atherosclerosis at its origin. Intracranially, left ICA is of good caliber. Left ophthalmic artery and anterior choroidal artery are visualized. Left fetal posterior cerebral artery is visualized. Left MCA and its branches are visualized. Left ACA and its branches are visualized. Capillary filling and venous drainage is normal
Left ECA and its branches are visualized.

NYU Langone Radiology
NYU Lutheran
150 55th Street, 3rd Floor
Brooklyn, NY 11220-2508
718-630-7400

There is no evidence of any intracranial/extracranial dural AV fistulas or AV malformations on these images.

3-dimensional rotational angiographic imaging of the left ICA:
There is no evidence of any aneurysms in this distribution

Right subclavian artery:
Right subclavian artery is of good caliber. Right vertebral artery has no evidence of atherosclerosis at its origin

Right vertebral artery:
Right vertebral artery is the dominant vertebral artery. Right PICA is visualized. Bilateral AICA are visualized. Bilateral SCA and Right PCA are visualized. Left PCA is hypoplastic. Capillary filling and venous drainage is normal.
There is no evidence of any intracranial/extracranial dural AV fistulas or AV malformations on these images.

Right common femoral artery: 36245
Right common femoral artery is visualized. The puncture site is in the mid common femoral artery proximal to its bifurcation. Both the superficial as well as the deep femoral artery are visualized with anterograde flow. There is no evidence of any dissection or occlusion proximally or distally to the site of puncture. 75736

HEMOSTASIS: The diagnostic catheter and glide wire were completely removed. A 5 French Mynx was deployed through the short sheath to achieve hemostasis.

COMPLICATIONS: The patient tolerated the procedure well. There were no complications during the procedure.

FLUOROSCOPY TIME:
AP= 8.9 min
Lateral= 1.6 min

Impression: No evidence of AVM, dAVF or aneurysms or cortical venous thrombosis

INTRAOPERATIVE MEDICATIONS:
Pre-op Antibiotics

MATERIALS UTILIZED:
5 French, 10 cm Pinnacle short sheath
5 French, 100 cm diagnostic catheter: Davis
0.35" Terumo Glidewire, 150 cm
5 French Mynx

If you have any questions regarding this procedure or regarding the patient please do not hesitate to contact me at 718-6306756.

NYU Langone Radiology
NYU Lutheran
150 55th Street, 3rd Floor
Brooklyn, NY 11220-2508
718-630-7400

Sincerely,

Ambooj Tiwari, MD
Interventional & Vascular Neurology
Lutheran Medical Center

I personally reviewed the images and agree with this report. Final Report: Dictated by and Signed by Attending Ambooj Tiwari MD 5/24/2017 3:10 PM

EXHIBIT B

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

HIP - HEALTH INSURANCE PLAN OF GREATER NEW YO
PO BOX 2845
NEW YORK, NY 10116

CARRIER

PICA

1. MEDICARE (Medicare #) MEDICAID (Medicaid #) TRICARE (ID/DOD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#) ☑

1a. INSURED'S I.D. NUMBER (For Program in Item 1): 19063168

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): [redacted] Noe

3. PATIENT'S BIRTH DATE MM DD YY: [redacted] SEX M ☑ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial): [redacted] Noe

5. PATIENT'S ADDRESS (No., Street): [redacted]

6. PATIENT RELATIONSHIP TO INSURED: Self ☑ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street): [redacted]

CITY: [redacted] STATE: [redacted]

8. RESERVED FOR NUCC USE

CITY: [redacted] STATE: [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

ZIP CODE: [redacted] TELEPHONE (Include Area Code): [redacted]

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑

a. INSURED'S DATE OF BIRTH MM DD YY: 06 06 1966 SEX M ☑ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES ☐ NO ☑

c. INSURANCE PLAN NAME OR PROGRAM NAME: HIP - Health Insurance Plan of Gre

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 21 17 TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0

A. I61.8 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. (EPSDT Family Plan)	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	05 23 17	05 23 17	21	Y	36226		a	32000 00	1		NPI	1609198779
2	05 23 17	05 23 17	21	Y	36225	59	a	32000 00	1		NPI	1609198779
3	05 23 17	05 23 17	21	Y	36223	50 59	a	64000 00	1		NPI	1609198779
4	05 23 17	05 23 17	21	Y	36245	59	a	5125 00	1		NPI	1609198779
5	05 23 17	05 23 17	21	Y	75736	26 59	a	1250 00	1		NPI	1609198779
6	05 23 17	05 23 17	21	Y	75710	26 59	a	2311 77	1		NPI	1609198779

25. FEDERAL TAX I.D. NUMBER: 461672913 SSN ☐ EIN ☑

26. PATIENT'S ACCOUNT NO.: 065702057988500

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐

28. TOTAL CHARGE: $ 136686 77

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

A. Tiwari
04/23/2018
SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION
Lutheran Medical Center INPT
150 55th Street
Brooklyn, NY 11220
a. 1609198779

33. BILLING PROVIDER INFO & PH # (201) 387-1957
Jeffrey Farkas MD, LLC DBA Interventio
43 Westminster Avenue
Bergenfield, NJ 07621
a. 1114267929

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

HIP - HEALTH INSURANCE PLAN OF GREATER NEW YO
PO BOX 2845
NEW YORK, NY 10116

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE ☐ (Medicare #) MEDICAID ☐ (Medicaid #) TRICARE ☐ (ID/DOD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☑ (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1) 19063168
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) S[redacted] Noe	3. PATIENT'S BIRTH DATE [redacted] SEX M ☑ F ☐	4. INSURED'S NAME (Last Name, First Name, Middle Initial) S[redacted] Noe
5. PATIENT'S ADDRESS (No., Street) [redacted]	6. PATIENT RELATIONSHIP TO INSURED Self ☑ Spouse ☐ Child ☐ Other ☐	7. INSURED'S ADDRESS (No., Street) [redacted]
CITY [redacted] STATE [redacted]	8. RESERVED FOR NUCC USE	CITY [redacted] STATE [redacted]
ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]		ZIP CODE [redacted] TELEPHONE (Include Area Code) [redacted]
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES ☐ NO ☑	a. INSURED'S DATE OF BIRTH MM DD YY [redacted] SEX M ☑ F ☐
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES ☐ NO ☑ PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES ☐ NO ☑	c. INSURANCE PLAN NAME OR PROGRAM NAME HIP - Health Insurance Plan of Grei
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☑ If yes, complete items 9, 9a and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP): MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM 06 21 17 TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0 A. I61.8 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 05 23 17 05 23 17	21	Y	76377	26 59	a	700 00	1		NPI	1609198779
2									NPI	
3									NPI	
4									NPI	
5									NPI	
6									NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☑ 461672913	26. PATIENT'S ACCOUNT NO. 065702057988500	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☑ NO ☐	28. TOTAL CHARGE $ 700 00	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) A. Tiwari SIGNED 04/23/2018 DATE	32. SERVICE FACILITY LOCATION INFORMATION Lutheran Medical Center INPT 150 55th Street Brooklyn, NY 11220 a. 1609198779		33. BILLING PROVIDER INFO & PH # (201) 387-1957 Jeffrey Farkas MD, LLC DBA Interventio 43 Westminster Avenue Bergenfield, NJ 07621 a. 1114267929		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT C

0008848150

AGREEMENT

MEDICAL AUDIT & REVIEW SYSTEMS

PLEASE RETURN IMMEDIATELY FOR PROMPT PAYMENT

MARS Claim #: 27C68EBFF4
Payor Claim #: 201720174188803

PATIENT: S[redacted], NOE	PROVIDER: Jeffrey Farkas MD LLC
PATIENT DOB: [redacted]	PROVIDER TAX ID: 46-1672013
PAYOR/CLIENT (via MULTIPLAN): Health Insurance Plan of Greater NY	DATE(S) OF SERVICE: 05/23/2017
AMOUNT OF CLAIM/BILL: $137,366.77	AGREED AMOUNT: $107,000.00

SIGNATURES

By signing below, the Provider agrees to: (i) accept the Agreed Amount (less deductible, co-insurance, co-payment or other patient responsibility or non-covered services as defined by the plan) as payment in full for claims/bills from plans serviced by MultiPlan that are submitted by Payor/Client and determined to be eligible for the services rendered to the Patient on the dates listed above; (ii) not to balance bill the Patient for the difference between the Amount of the Claim/Bill and the Agreed Amount; and (iii) reduce the liability of the Patient and Payor/Client.

By signing below, the Provider agrees and acknowledges that: (i) MARS and MultiPlan are not payors and are not financially responsible for any payments due to the Provider; (ii) the payment of benefits, if any, is subject to the terms and conditions of the Patient's plan; and (iii) this agreement does not constitute, nor should it be construed as a guarantee of benefit payment by the Payor/Client. Provider retains the right to bill the Patient (or financially responsible party) for items not covered under the Patient's benefit plan.

- Provider agrees to accept the above, provided that payment is released within 4 business days from date of receipt of faxed/digital signature.

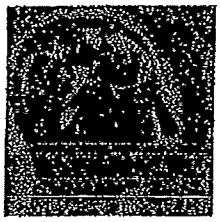
Tammie C Farkas 8/23/17 — Tammie C. Farkas/Practice Manager

PROVIDER OR AUTHORIZED REPRESENTATIVE'S SIGNATURE / DATE — PRINT AUTHORIZED REPRESENTATIVE'S NAME/ TITLE

If not the Provider, the signatory to this agreement represents and warrants that he/she is signing on behalf of Provider and is fully authorized to sign and commit Provider to all of its obligations and responsibilities under this agreement.

For questions or concerns, please call Dan Lacey IA-1368186 (NY State License) at (610) 557-6878. To allow for timely processing of this Claim, please sign and return to MARS via fax (888 331-7764) or e-mail (claims@marsauditor.com). Thank you.

EXHIBIT D



Jeffrey Farkas MD, LLC DBA Interventional Neuro Associates

Jennifer Dillon
Billing Specialist

43 Westminster Avenue
Bergenfield, NJ 07621
P: 201-387-1957 F: 201-387-1036
tfarkas@intneuro.org

HIP
Attn: Appeals
PO Box 2844
New York, NY 10116

November 13, 2017

First Level Appeal

Member Name:
[redacted]

Claim #:
201720174168803

Member Id:
19063168

Member Address:
[redacted]

Date of Birth:
[redacted]

Date of Service:
05/23/2017

A review of this file indicates that the above captioned matter was unpaid and/or underpaid. Please review your claim reimbursement determination and issue the unpaid and/or underpaid balance immediately.

On 09/13/2017 we signed an agreement to accept $107,000.00 as payment in full for date of service 05/23/2017. We agreed to accept this amount provided the payment is released within 4 business days. The payment is now two months late and needs to paid immediately with interest.

In furtherance of its request for benefits on behalf of the patient named in this appeal, Jeffrey Farkas MD, LLC, FORMALLY REQUESTS that you provide the following documents for the member immediately:

- The name, address and contact information of any other party of interest including but not limited to the Plan Administrator and named or un-named fiduciaries, Claims Administrator, Third-Party Administrator, additional insurance Companies involved in the claims process, and any other entities involved in the claims process;
- A true and exact copy of the applicable Health Insurance Policy, Summary Plan Description, and Plan for the time period at issue;
- The Plan Name, Plan Sponsor (including its name and address for service of legal process);
- The specific reason(s) for your denial of the full amount of the claim submitted;
- Reference to the specific Plan provisions on which your determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- The methodology by which you computed the Usual and Customary Rate, including copies of all specific rules, guidelines, protocols, or other similar criteria on which you relied in making this benefit determination;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances;
- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an in network service;
- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an out of network service;
- The name of the publication, database, documentation, Medicare guidelines etc., of all documents and databases used in computing the Usual and Customary Rate, and copies of all such documents;
- Provide copies of any and all algorithm, formula, procedure or fee schedule used to derive the customary and reasonable reimbursement rate in this matter;
- Copies of any and all documentation, including but not limited to manuals, statutes, rules, regulations, books and/or industry standards which refer to, reflect or otherwise relate to the computation of reimbursement for the date of service in question.

- This request for documents is pursuant to United States Department of Labor regulations requiring Plans to make disclosure of its claims procedures. See 29 C.F.R. 2560.503-1. The Plan is required to provide this requested documentation upon request and free of charge.
- This request also comports with U.S. Department of Labor regulations that provide, "[a] Plan's claims procedures may not preclude an authorized representative (including a health care provider) from acting on behalf of a Claimant..." As the authorized representative of Jeffrey Farkas MD, LLC, the Plan is required by law to provide this documentation to us forthwith.

Kindly note, an enrollee/beneficiary may file suit against a Plan Administrator who fails to comply with the enrollee's/beneficiary's request for documentation purporting to support the Plan's benefit determinations. Section 502(a)(1)(A) of ERISA and its implementing regulations require the Plan Administrator to provide these documents upon request to the enrollee/beneficiary no more than thirty (30) days after such request has been made. The Plan Administrator may be held liable for up to $110.00 per day for each day he/she fails to provide this required disclosure of documentation to the enrollee/beneficiary. As set forth above, this is a formal request for disclosure of documents pursuant to Department of Labor regulations, for the purpose of enabling us to evaluate whether the Plan has properly exercised its discretion in its benefit determination.

If this appeal requires additional documentation pursuant to the member's plan or policy, kindly advise the undersigned via letter or facsimile.

Thank you for your prompt response to this request.

Sincerely,

Jennifer Dillon

EXHIBIT E

1 of 10

* 2nd Submission *

INTERVENTIONAL NEURO ASSOCIATES

Jeffrey Farkas MD, LLC
DBA Interventional Neuro Associates

Interventional Neuro Associates
43 Westminster Avenue
Bergenfield, NJ 07621
Tel: 201-387-1957
Fax: 201-387-1036

HIP
Attn: Appeals
P.O. Box 2844
New York, NY 10116

December 4, 2017

Second Level Appeal

Member Name:	N[redacted]	Date of Service:	05/23/2017
Member ID:	19063168	Claim ID:	2017201741688803
Date of Birth:	[redacted]		
Member Address:	[redacted]	Total Claim Amount:	$137,386.77

A review of this file indicates that the above captioned matters were unpaid and/or underpaid. Please review your claim reimbursement determination and issue the unpaid and/or underpaid balance immediately.

On 09/13/2017 we signed an agreement to accept $107,000.00 as payment in full for date of service 05/23/2017.We agreed to accept this amount provided the payment is released within 4 business days. The payment is now two months late and needs to pay immediately with interest.

Since this was a contracted agreement, at this point it is outside the realm of the state arbitration system and we will be giving this case over to our legal team for litigation if the signed settlement is not honored with the interest payment for late payment.

Please review and remit the remaining balance of $97,971.00 immediately.

In furtherance of its request for benefits on behalf of the patient named in this appeal, Jeffrey Farkas MD, LLC, FORMALLY REQUESTS that you provide the following documents for the member immediately:

- The name, address and contact information of any other party of interest including but not limited to the Plan Administrator and named or un-named fiduciaries, Claims Administrator, Third-Party Administrator, additional Insurance Companies involved in the claims process, and any other entities involved in the claims process;
- A true and exact copy of the applicable Health Insurance Policy, Summary Plan Description, and Plan for the time period at issue;
- The Plan Name, Plan Sponsor (including its name and address for service of legal process);
- The specific reason(s) for your denial of the full amount of the claim submitted;
- Reference to the specific Plan provisions on which your determination was based;
- A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- The methodology by which you computed the Usual and Customary Rate, including copies of all specific rules, guidelines, protocols, or other similar criteria on which you relied in making this benefit determination;
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances;
- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an in-network service;

2 of 10

- Copies of representative documents (with private information redacted to comply with privacy laws) showing payments made by the Plan to this healthcare provider and similar healthcare providers for comparable services as an out of network service;
- The name of the publication, database, documentation, Medicare guidelines etc., of all documents and databases used in computing the Usual and Customary Rate, and copies of all such documents;
- Provide copies of any and all algorithm, formula, procedure or fee schedule used to derive the customary and reasonable reimbursement rate in this matter;
- Copies of any and all documentation, including but not limited to manuals, statutes, rules, regulations, books and/or industry standards which refer to, reflect or otherwise relate to the computation of reimbursement for the date of service in question.
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Thank you for your prompt response to this request.

EXHIBIT F

HIP®
an EmblemHealth company

HIP Health Plan of New York
PO Box 2814
New York, NY 10116-2814

Facility Claims
Payment Report

06/26/2018

JEFFREY FARKAS MD LLC
43 WESTMINSTER AVE
BERGENFIELD, NJ 07621-3913

Provider	JEFFREY FARKAS MD LLC
Remit#	2018177100572
TIN	XXXXX2913 000

Please be sure to use your ten-digit NPI number in all claim submissions, as required by federal law, to ensure accurate and timely processing of your claims. For more information, visit the EmblemHealth Website at www.emblemhealth.com

CHECK ENCLOSED

Summary of Claims

Amount we paid toward these claims	$9,109.35
Check Number	57229810
Check date	06/26/2018

This remittance advice associated to this check has been sent to you, or your billing agent, in an electronic format. If you have any questions, please contact EDI Helpdesk line at 212-615-4362.

FOR SECURITY PURPOSES, THE PAGE OF THIS DOCUMENT CONTAINS A BLUE BACKGROUND AND MICROPRINTING IN THE BORDER

HIP®
an EmblemHealth company

HIP Health Plan of New York
PO Box 2814
New York, NY 10116-2814
CUSTOMER SERVICE: 1-866-447-9717 – OPTION #2
PROFESSIONAL CARE ACCOUNT

Remit: 2018177100572
Payee: XXXXX2913 000
Check Number: 57229810
Check Date: 06/26/2018

62-35
311

This amount: Nine Thousand One Hundred Nine & 35/100 Dollars **$9,109.35

Void if not cashed within 6 months

Pay to the order of: JEFFREY FARKAS MD LLC
43 WESTMINSTER AVE
BERGENFIELD, NJ 07621-3913

UNDER PROTEST WITH FULL RESERVATION OF RIGHTS

BNY Mellon Trust of Delaware
Wilmington, DE

Authorized Signature

DO NOT CASH IF WATERMARK IS NOT PRESENT ON THE REVERSE SIDE OF THIS DOCUMENT - HOLD AT AN ANGLE TO VIEW

⑈57229810⑈ ⑆031100351⑆ 0300970480⑈

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